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IN THE
SUPREME COURT OF THE UNITED STATES
OCTOBER TERM, 1998

AMERICAN MANUFACTURERS MUTUAL INSURANCE COMPANY, *et al.*,
Petitioners,

v.

DELORES SCOTT SULLIVAN, *et al.*,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Third Circuit

BRIEF *AMICI CURIAE* OF THE AMERICAN ASSOCIATION OF RETIRED PERSONS, THE CENTER FOR MEDICARE ADVOCACY, INC., THE NATIONAL CENTER FOR YOUTH LAW, THE NATIONAL HEALTH LAW PROGRAM, THE NATIONAL SENIOR CITIZENS LAW CENTER, AND THE NATIONAL PARTNERSHIP FOR WOMEN & FAMILIES IN SUPPORT OF RESPONDENTS

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INTEREST OF *AMICI CURIAE*[1]

Six national organizations join in this brief, which focuses solely on the first question before the Court, whether the petitioning insurance companies are state actors and therefore required to provide basic procedural protections guaranteed by the due process clause of the Fourteenth Amendment. As the

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[1] No counsel for any party authored any portion of this brief. No persons other than the *amici curiae*, their members, or their counsel made a monetary contribution to the preparation and submission of this brief.

following descriptions of those organizations demonstrate, they, their members, and their constituencies have a significant interest in the outcome of this case and in upholding the Third Circuit's determination that the insurance companies' activities amounted to state action pursuant to prior decisions of this Court. See *Sullivan v. Barnett*, 139 F.3d 158 (3d Cir.), *cert. granted sub nom. American Manufacturers Mutual Ins. Co. v. Sullivan*, 119 S. Ct. 128 (1998).

The American Association of Retired Persons (AARP), a nonprofit membership organization of more than 32 million Americans age 50 or older, is dedicated to addressing the needs and interests of older people. Through education, advocacy, and service, and by promoting independence, dignity, and purpose, AARP seeks to enhance the quality of life for all citizens. In the effort to promote independence, AARP works to foster the health and economic security of individuals as they age by attempting to ensure the availability of quality and economical health coverage.

The Center for Medicare Advocacy, Inc., which is staffed by attorneys, paralegals, a nurse, and technical assistants, provides legal advice, self-help materials, and representation to the elderly and disabled who are unfairly denied Medicare coverage. The Center's work includes responding to over 8,000 telephone calls annually, producing educational materials, pursuing Medicare coverage for beneficiaries who are eligible for both Medicare and Medicaid, and engaging in litigation of national importance. Furthermore, the Center annually represents hundreds of individuals in appeals of Medicare denials, particularly for home health care, and its staff members act as consultants and trainers for groups which are interested in learning about Medicare coverage and appeals or in developing Medicare advocacy projects.

The National Center for Youth Law (NCYL) is a nonprofit corporation which represents the interests of poor children and adolescents in civil litigation. It also assists attorneys nationwide in representing their indigent clients, and is the primary national resource on children's issues to more than 6,000 legal services attorneys and paralegals who request advice, written materials, trainings, mentoring, and co-counseling. NCYL's clients are regular beneficiaries of government-sponsored health care programs, such as Medicaid, and NCYL frequently acts to enforce the rights of children and adolescents in these programs under state or federal law.

The National Health Law Program (NHeLP) is a national public interest law firm that seeks to improve health care for America's working and unemployed poor, minorities, children, elderly, and people with disabilities. NHeLP serves legal services programs, protection and advocacy offices, community-based organizations, the private bar, providers, and individuals who work to maintain a health care safety net for millions of low income people. NHeLP monitors Medicaid, Medicare, and other publicly-funded health care programs, seeks remedies when laws and policies are ignored, and helps Americans to receive needed medical care.

The National Senior Citizens Law Center (NSCLC) is a nonprofit organization that advocates on behalf of elderly poor people. Since its formation in 1972, NSCLC has engaged in litigation, legislative and administrative advocacy, technical assistance, and training in many areas of elder law, including Medicare and Medicaid. NSCLC has brought numerous law suits on behalf of Medicare beneficiaries and Medicaid recipients to protect their rights under these federal statutes and their implementing regulations, and under the Constitution.

The National Partnership for Women & Families (National Partnership) is a national advocacy organization that develops and promotes policies to help women achieve equal opportunity and obtain quality health care and economic security for themselves and their families. Founded in 1971 as the Women's Legal Defense Fund, the National Partnership works to improve access to quality health care through research and analysis, public education, advocacy, and litigation of significant cases. The National Partnership is a leading voice in the effort to ensure that women and families receive quality health care through their health insurance plans, including managed health care plans.

Each of the *amici* organizations thus advocates on behalf of individuals throughout the country, seeking especially to ensure access to health care and to protect and enhance their rights to obtain quality health care. For instance, AARP filed a brief *amicus curiae* last Term in support of the ultimately victorious petitioners in *Geissal v. Moore Medical Corp.*, 118 S. Ct. 1869 (1998). Similarly, attorneys for the Center for Medicare Advocacy represent a nationwide class of plaintiffs in a successful due process challenge which raises the issue of state action in a Medicare context, with AARP filing a supporting *amicus* brief in the Court of Appeals. See *Grijalva v. Shalala*, 152 F.3d 1115 (9th Cir. 1998). And, the Center for Medicare Advocacy, NSCLC, and AARP are co-counsel for a nationwide class of Medicare beneficiaries seeking to enforce procedural protections for recipients of home health care. *Healey v. Shalala*, No. 398CV00418DJS (D.Conn. filed March 4, 1998).

The instant case is of particular concern to the *amici* organizations because of its potentially broad and significant impact on their members and constituencies. The state action issue is obviously of great importance in the context of

workers' compensation programs, and the decision's effect on that aspect alone of the nation's health care system would warrant attention. More broadly, however, this Court's resolution may affect the rights to and surrounding health care in numerous other situations, as petitioners themselves recognize, see Reply Brief for Petitioners on Petition for Writ of Certiorari, at 5 & n.2, and as the courts have begun to address.[2/] As the relationships between state and federal governments on the one hand, and private companies involved in the health care industry on the other, are encouraged and grow, the administration of the nation's health care system is increasingly becoming a joint venture, with dramatic ramifications for the rights of those dependent on that system.

Historically, the two most important public health care programs, Medicare and Medicaid, have involved private entities to some degree. Medicaid, a welfare program administered by each state subject to federal statutory and regulatory requirements, see, *e.g., Atkins v. Rivera*, 477 U.S. 154, 156-157 (1986), pays private individuals and institutions to provide the actual health care. Medicare, a federal insurance program, not only relies on private providers but also utilizes insurance companies to administer the program and distribute payments. See, *e.g., Bodimetric Health Services, Inc. v. Aetna Life & Casualty*, 903 F.2d 480, 482 n.3 (7th Cir. 1990). As managed care models become increasingly more prevalent in

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[2/] For instance, state action holdings have played crucial roles in enforcing procedural rights of beneficiaries of state Medicaid programs. See, *e.g., Catanzano v. Dowling*, 60 F.3d 113, 117-120 (2d Cir. 1995); *Perry v. Chen*, 985 F. Supp. 1197, 1201-1202 (D. Ariz. 1996). Similarly, the right to effective notices and timely hearings for Medicare beneficiaries enrolled in HMOs has largely hinged on the state action question. *Grijalva*, 152 F.3d at 1119-1121.

these public programs, however, the extent and context of the private sector participation is dramatically changing.

The line between providers and insurance companies is becoming less distinct, and decisions regarding the appropriateness of particular health care are being made before, not after, that care is provided. Under the traditional fee-for-service system, doctors provided the care and the question of reimbursement came later; under managed care, where payment is typically on a "capitated" basis (with the plan receiving a set monthly amount per enrollee regardless of usage), there are strong economic incentives for a private plan to question a suggested course of treatment. See, *e.g., Herdrich v. Pegram,* 154 F.3d 362, 375 (7th Cir. 1998). This evolving new role for the private entities involved in publicly funded and authorized health programs renders their decision-making processes more important than ever.

This increasing "privatization" of benefit programs is moving forward rapidly. As of June 1997, more than 15 million Medicaid beneficiaries -- almost 48% of the Medicaid population -- were enrolled in managed care plans, a dramatic increase from the 2.7 million who had been enrolled just six years earlier. Health Care Financing Administration, *National Summary of Medicaid Managed Care Programs and Enrollment* at 1 (Data as of June 30, 1997) <http://www.hcfa.gov/medicaid/trends97.htm>. And, since 1988, the annual increase in Medicare beneficiaries enrolled in risk-based HMOs has been as high as 36%, and in 1998 is still over 20%, "far surpassing the annual growth in the beneficiary population," which has stayed well below 5%. Medicare Payment Advisory Commission, *Health Care Spending and the Medicare Program: A Data Book*, at 30 (July 1998). Nationwide, more than 50,000 Medicare beneficiaries enroll in these plans every month, *id.,* with over six million presently

enrolled. Health Care Financing Administration, *Medicare Managed Care Contract Report* at 1 (Data as of Nov.1,1998) <http://www.hcfa.gov/stats/mmcc1198.txt>.

Of no less importance than this past growth is that January 1, 1999 marks the beginning date of the Medicare+Choice program, Balanced Budget Act of 1997, Pub. L. No. 105-33, § 4001, 111 Stat. 251, 275 (1997), which is intended to change the very nature of the Medicare program: "Alternatives available to beneficiaries under the M+C program include both the traditional managed care plans (such as HMOs) that have participated in Medicare on a capitated payment basis ... as well as a broader range of plans comparable to those now available through private insurance ...." 63 Fed. Reg. 34968 (June 26, 1998). In short, spurred by Congressional action, the Medicare program is aggressively encouraging increased beneficiary participation in private managed care structures.[y] This will increasingly place private entities into relationships with beneficiaries that previously had been the province of government agencies or their agents, which, of course, are subject to constitutional restraints.

The evolution in the administration of government benefit programs thus renders the state action determination important to a rapidly expanding number of individuals. Whether in the context of workers' compensation, Medicaid, Medicare, or any of a host of other programs devised and administered by state and federal governments to secure economic and health security for vulnerable populations, the active participation of private

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[y] It is also anticipated that there will be significant growth in managed care enrollment of Medicaid beneficiaries, as states are now permitted to require their participation in managed care plans without obtaining a waiver from the federal government. Balanced Budget Act of 1997, Pub. L. No. 105-33, § 4701(a), 111 Stat. 251, 489 (1997).

entities has become a critical component, but that development should not occasion a deprivation of individual rights. Judge Wiggins observed for the Ninth Circuit that "the government cannot avoid the due process requirements of the Constitution merely by delegating its duty to determine Medicare coverage to private entities," *Grijalva*, 152 F.3d at 1121, and, on behalf of their members and constituencies, the *amici* organizations are anxious to see that position upheld in the overall context of the state action inquiry.[4/]

SUMMARY OF ARGUMENT

Although the theory of state action is a difficult concept and its evolution has engendered considerable debate, this Court has developed and consistently employed a two-step process. *Lugar v. Edmondson Oil Co.*, 457 U.S. 922, 937 (1982). As Justice White explained for the Court in that decision, the first step requires a determination of whether the state has authorized the conduct at issue, and the second looks to the additional factors which would convert private action into state action. The three principles necessary to make this second determination, by evaluating the totality of the circumstances, were explicitly outlined in *Edmonson v. Leesville Concrete Co., Inc.*, 500 U.S. 614 (1991) and reiterated in *Georgia v. McCollum*, 505 U.S. 42 (1992). These decisions have not been overruled, and the court below relied on and applied their principles in making its decision.

Since suspension of medical coverage was here authorized by the statute, there is no doubt that the first *Lugar* step is met. In considering the first of *Edmonson*'s three principles relevant

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[4/] The blanket written consents of the parties to the filing of *amicus curiae* briefs has been filed with the Clerk of the Court pursuant to Supreme Court Rule 37.3.

to the second step, the Third Circuit correctly noted the insurance companies' significant reliance on governmental assistance in effecting the suspensions. The state is involved in every facet of the dispute resolution process, and it could not be accomplished without the state's consistent involvement. The court below also noted that suspension of benefits pending dispute resolution is a traditional governmental function in benefit programs. Third, the state aggravates the harm by locking injured workers into a system which was intended to provide a balance between the needs and rights of all parties but which instead gives the insurers a significant advantage by allowing unilateral suspension of health coverage with the support and approval of the state. Especially when viewed together, these factors conclusively demonstrate that the insurance companies are state actors.

ARGUMENT

THE COURT BELOW CORRECTLY APPLIED THE PRINCIPLES WHICH HAVE BEEN ESTABLISHED BY THIS COURT AND FORMULATED INTO A CLEARLY STATED FRAMEWORK.

A. This Court should apply the state action test which it has developed over time and which it has now definitively delineated.

1. It has become a truism that the state action inquiry is a difficult one, which "frequently admits of no easy answer." *Jackson v. Metropolitan Edison Co.*, 419 U.S. 345, 350 (1974). The court below termed it "one of the most troublesome issues of constitutional law," *Sullivan*, 139 F.3d at 167, and this Court recently acknowledged again the "difficult terrain". *Lebron v. National R.R. Passenger Corp.*, 513 U.S. 374, 378 (1995).

Not surprisingly, the commentators have been anxious to propose their solutions to the apparent dilemma,[3/] appearing almost gleeful in their criticism. One 1991 analysis stated that "nearly every article about the state action doctrine published in the last twenty years quotes and concurs with Professor Charles Black's characterization of the doctrine as 'a conceptual disaster area,'" Henry C. Strickland, *The State Action Doctrine and the Rehnquist Court*, 18 HASTINGS CONST. L.Q. 587, 588 (1991) (citation omitted), while another contends that the doctrine "remains a dark thicket of constitutional law." Ronald J. Krotoszynski, Jr., *Back to the Briarpatch: An Argument in Favor of Constitutional Meta-analysis in State Action Determinations*, 94 MICH. L. REV. 302, 303 (1995)[hereinafter, *Constitutional Meta-Analysis*].

The difficulty of devising a state action standard, however, should not lead to despair that such a task is impossible -- or that, as one of the *amicus* briefs supporting petitioners expressly requests, the Court simply replace the existing standard. See Br. *Amicus Curiae* on Behalf of the National Ass'n of Waterfront Employers, *et al.*, at 15-17 (urging "two clarifications"). Indeed, the irony of attacking the Court's efforts to develop a fair and effective analytical tool is that the Court has already done exactly that. While there undoubtedly have been fits and starts in the process, and, as the Court itself has noted, its decisions in the area "have not been a model of consistency," *Lebron*, 513 U.S. at 378 (quoting *Edmonson v. Leesville Concrete Co., Inc.*, 500 U.S. 614, 632 (1991) (O'Connor, J., dissenting)), the Court, after analyzing state action in a wide variety of legal and factual circumstances, has

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[3/] *See, e.g.*, Barbara Rook Snyder, *Private Motivation, State Action and the Allocation of Responsibility for Fourteenth Amendment Violations*, 75 CORNELL L. REV. 1053 (1990); Erwin Chemerinsky, *Rethinking State Action*, 80 NW. U. L. REV. 503 (1985).

arranged those considerations into a viable conceptual framework. While some factors were originally evaluated independent of an integrated test, the Court has now described and applied a mechanism which both observes past precedent and provides appropriate guideposts for future guidance.

2. The first step to effect this organizational arrangement took place in 1982, when the Court summarized its previous holdings as "insist[ing] that the conduct allegedly causing the deprivation of a federal right be fairly attributable to the State." *Lugar v. Edmondson Oil Co.*, 457 U.S. 922, 937 (1982). To establish this "fair attribution", the Court divined, from prior cases, two necessary components or principles:

> First, the deprivation must be caused by the exercise of some right or privilege created by the State or by a rule of conduct imposed by the State or by a person for whom the State is responsible .... Second, the party charged with the deprivation must be a person who may fairly be said to be a state actor.

Id.

Although this clear-cut statement and summary of the law remains the standard for determining state action, petitioners are determined to undercut its effective application. In a transparent attempt to secure a rule which is less likely to bind them to the inconvenient standards applicable to the government, petitioners and their supporting *amici* are ready and willing to decry the state of state action law and to request that the Court "bring order to this cacophony." Petition for Writ of Certiorari (Pet. Writ Cert.) at 22. They begin this attack by dismissing the first component of the *Lugar* test as essentially meaningless, describing it as relevant only when the

private entity violates the law. Brief for Petitioners (Br. Pet'r) at 14.

Justice White, the author of *Lugar*, explained the broader sweep of that component by comparing two prior decisions. In one, *Moose Lodge No. 107 v. Irvis*, 407 U.S. 163 (1972), the Court had reached its conclusion of no state action by "focus[ing] primarily on the question of whether the admittedly discriminatory policy could in any way be ascribed to a governmental decision." *Lugar*, 457 U.S. at 937-938. By contrast, in the second, *Flagg Bros., Inc. v. Brooks*, 436 U.S. 149 (1978), since "the State was responsible for the statute" at issue, the analysis was directed at "the other component of the state-action principle." *Lugar*, 457 U.S. at 938.[6] While illegal action by the private entity may place its behavior outside the realm of state action, that is only part of the equation: *any* conduct carried out without the authorization of the state has the same effect and cannot be state action. In short, *Lugar*'s first component allows a holding of state action only when the state has sanctioned a private entity to undertake the allegedly impermissible conduct. See also, *e.g., Edmonson v. Leesville Concrete Co., Inc.*, 500 U.S. 614, 620-621 (1991).

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[6] Justice White added further explanation through his concurrences to two other state action cases decided on the same day as *Lugar*. In both, he agreed that there was no state action because the activity at issue was not based on conduct or policy of the state. See *Rendell-Baker v. Kohn*, 457 U.S. 830, 843-844 (1982) (White, J., concurring in the judgment); *Blum v. Yaretsky*, 457 U.S. 991, 1012 (1982) (White, J., concurring in the judgment). And, as Justice White added, this was, for all practical purposes, the crucial factor in the majority's *Blum* analysis: "This is the clear import of the majority's conclusion that the 'decisions ultimately turn on medical judgments made by private parties according to professional standards that are not established by the state ....'" *Id.* (citation omitted).

The second *Lugar* principle elicits equal disdain from petitioners; it is, they say, "with all due respect, ... tautological." Pet. Writ Cert. at 21. But Justice White's opinion speaks directly to the several concerns which had motivated the Court through the years of state action analysis. He focused on the fact that, once the state's involvement had been established through a rule or policy (the first component), the next step was to determine whether there existed "'something more' which would convert the private party into a state actor ...." *Lugar,* 457 U.S. at 939. To make this determination requires the practical and realistic recognition that state action may exist in a variety of circumstances, and that, to respond to these variations, the Court has "articulated a number of different factors or tests in different contexts." *Id.* Although the Court has attached various labels to the several "tests" which it has employed and the commentators have attempted to further refine them or suggested other terminology to describe them,[7] the bottom line of this second component is the recognition first stated in 1961: "'Only by sifting facts and weighing circumstances can the nonobvious involvement of the State in private conduct be attributed its true significance.'" *Id.* at 939 (quoting *Burton v. Wilmington Parking Auth.*, 365 U.S. 715, 722 (1961)). The precise nature of these tests -- whether they "are actually different in operation or simply different ways of characterizing the necessarily fact-bound inquiry that confronts the Court in such a situation" -- need not be resolved. *Lugar*, 457 U.S. at 939. The second component therefore incorporates the considerations which imbue the actions of a private party with the state's mantle.

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[7] See, *e.g.*, G. Sidney Buchanan, *A Conceptual History of the State Action Doctrine: The Search for Governmental Responsibility (I)*, 34 HOUS. L. REV. 333, 345-351 (1997); *Constitutional Meta-Analysis*, *supra*, at 318-320.

3. Nine years later, in *Edmonson*, a case which petitioners mention only in passing (see Br. Pet'r at 14, 18, 24) and with studied indifference to its significance and relevance, the Court took the next step in summarizing and setting out the guiding principles for state action analysis. Applying "the framework for state-action analysis set forth in *Lugar*," the Court concluded that the first component was met, as the right to peremptory challenges clearly derived from state authority. *Edmonson*, 500 U.S. at 620-621.

The Court then described the critical inquiry relating to the second component:

> [O]ur cases disclose certain principles of general application. Our precedents establish that ... it is relevant to examine the following: the extent to which the actor relies on governmental assistance and benefits ...; whether the actor is performing a traditional governmental function ...; and whether the injury caused is aggravated in a unique way by the incidents of governmental authority ....

Id. at 621-622 (citations omitted). Applying "these three principles to the circumstances" of the case, a court may then determine whether the second aspect of the *Lugar* framework is satisfied. *Id.* at 622.

The *Edmonson* Court reviewed the three principles in turn, relying on prior decisions to provide the supporting analysis. In so doing, the Court indicated that no one factor is determinative, that they are not discrete or distinct tests which require complete satisfaction in order for state action to exist; rather, "the principles of general application" should be looked at in each instance to determine whether, in light of the totality of those circumstances, the private entity may be deemed a

government actor. As Judge Greenberg of the Third Circuit has summarized:

> Rather than stating a series of discrete tests and applying them separately to determine whether each by itself is satisfied, the Court considered a number of factors, and weighed them to determine whether, all things considered, the otherwise private actor fairly could be deemed to be a state actor. Under that new framework, courts should consider the principles furthered by the previous tests as part of a single balancing and weighing approach. And it should apply to all cases involving the question of whether a private actor is engaged in state action.

Mark v. Borough of Hatboro, 51 F.3d 1137, 1156 (3d Cir. 1995) (Greenberg, J., concurring); see also *Grijalva*, 152 F.3d at 1120; accord, *Constitutional Meta-Analysis*, *supra*, at 337-345; G. Sidney Buchanan, *A Conceptual History of the State Action Doctrine: The Search for Governmental Responsibility (II)*, 34 HOUS. L. REV. 665, 756-764 (1997).

The actual application of the three principles summarized in *Edmonson* requires careful analysis of each situation's circumstances in light of this Court's prior decisions. That separate inquiry forms the next part of this brief, but the *amici* wish to emphasize that the *framework* for the state action inquiry has been conclusively established through *Lugar* and *Edmonson*. And that analytical approach was expressly reaffirmed in *Georgia v. McCollum*, 505 U.S. 42, 50-51 (1992).

Although neither the court below nor the Ninth Circuit in *Grijalva* referred to the *Lugar-Edmonson* model, by implication and explicit analysis both courts considered and applied the principles which this Court imported from previous decisions to define that framework. See *Grijalva*, 152 F.3d at 1119-

1120; *Sullivan*, 139 F.3d at 168-169. The petitioners' strident accusations -- that the Third Circuit "essentially threw up its hands, justifying its conclusion ... by reference to a congeries of seemingly unrelated factors", Pet. Writ Cert. at 22, and, instead of providing an "analytical structure", *id.*, "offered a vague set of truths, half-truths, and irrelevancies," Br. Pet'r at 14, and, further, "did not think it necessary to offer a coherent theory," *id.* at 15 -- misapprehends that court's reliance on the analyses which this Court has condoned. The court below merely failed to specify the precise contours of the tests and their place within the overall framework. In its substance, however, the analysis was entirely consistent with this Court's pronouncements, and no good reason exists to alter the roadmap which now provides clear directions.

B. The Third Circuit's analysis and conclusion rely on the principles and their application which the *Edmonson* Court gleaned from this Court's prior decisions.

1. In this case, there can be no dispute that the first step of the *Lugar* test -- that the deprivation at issue be caused "by the exercise of some right or privilege created by the State," 457 U.S. at 936 -- is met. Here, the denial of due process is authorized by the utilization review procedures and supersedeas mechanism in Pennsylvania Workers' Compensation Act, 77 Pa.Stat.Ann. § 531(5) and (6), and its implementing regulations. 34 Pa.Code § 127.208(e). A statute authorizing the action which forms the basis for the deprivation represents the paradigm for satisfaction of this first element. See, *e.g.*, *McCollum*, 505 U.S. at 51; *Edmonson*, 500 U.S. at 621. In all likelihood, because this step was so obviously met, the court

below saw no reason to state the point explicitly.[V] Indeed, on several occasions after the *Lugar* standard was announced, this Court itself neglected to mention specifically this first part of the test, see, *e.g.*, *Tulsa Professional Collection Services, Inc. v. Pope*, 485 U.S. 478, 485-486 (1988), but that failing does not imply that a court is operating without an "analytical structure".

2. In discussing the second part of the *Lugar* test, the Third Circuit did not announce that it was considering the three principles. But, again, the failure to do so does not condemn the analysis as inherently faulty, especially where, as here, the court demonstrated its awareness of the issues surrounding the state action inquiry -- the difficulty of application, the dependence "upon the factual contexts in which the controversies arise," and the use of variously worded standards and the problems thereby occasioned. *Sullivan*, 139 F.3d at 167.

First, the Third Circuit carefully examined the extent to which the insurance companies' actions in stopping payments relied on governmental assistance; it made clear that this was one of the relevant principles informing its conclusion that the insurers were state actors:

> The insurers have no power to deprive or terminate such benefits without the permission and participation of the Commonwealth .... [T]he Commonwealth is intimately involved in any decision by an insurer to terminate an employee's constitutionally protected benefits because an

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[V] The Ninth Circuit also failed to mention this aspect of the *Lugar* test, see *Grijalva*, 152 F.3d at 1119, and probably for the same reason. Since the HMOs were operating under the authority of the federal statutes and rules governing Medicare and pursuant to contract with the federal government, *id.* at 1117-1119, there could be no doubt on this point.

> insurer cannot suspend medical payments without first obtaining authorization from the Bureau. However this authorization may be characterized, any deprivation that occurs is predicated upon the State's involvement.

Id. at 168. Just as the private litigants in *Edmonson* were unable to exercise peremptory challenges without invoking the overt, significant assistance of the court, so too are the insurers unable to halt medical benefit payments without employing the power and assistance of state officials. The Pennsylvania statute specifies that an insurer may only be relieved of its obligation to pay for health coverage by following the utilization review procedures, which mandate significant state involvement. 77 Pa. Stat.Ann. § 531(5).

The state creates the system of utilization review ("UR") and must authorize and certify the organizations ("UROs") which will perform the reviews. 77 Pa.Stat.Ann. § 531(6)(i); 34 Pa. Code §§ 127.650-.670. The state mandates what kind of provider may perform the review, what the review process should be, how long it may take, and what information the URO may examine to reach its conclusion. 77 Pa. Stat.Ann. § 531(6)(ii); 34 Pa. Code §§ 127.461-.476. The state's implementing regulations provide that the insurance company's obligation to make payment within thirty days "may be tolled only if review . . . of the treatment is requested during the 30-day period under the UR provisions." 34 Pa. Code § 127.208(e).

Furthermore, the insurer's "request" for the UR is filed with the state on a state prescribed form, 34 Pa. Code § 127.452(a) and (c), which asks *the state* to invoke the statutorily created procedures of UR. 34 Pa. Code

§ 127.452(a).[2/] The state requires the insurer to certify that it served its request for UR on all parties, including the employee, but, significantly, does not require the insurer to provide notice that, once the state accepts the request, the insurer may terminate the injured employee's medical benefits during the review or for an even longer period of time, perhaps permanently. See 34 Pa. Code §§ 127.208 (e) - (g), 127.452.

If the state determines that the form has been properly completed, the state assigns the request to a URO and sends the Notice of Assignment to the URO, the employee, the employer, the insurer, and the provider. The Notice prominently features its origin: The Commonwealth of Pennsylvania, Department of Labor and Industry, Bureau of Workers' Compensation. J.A. at 6.

At this point, while the state-created URO resolves the dispute, the state may toll the insurer's obligation to pay for health coverage. 34 Pa. Code § 127.208(e). The URO reports to the state and sends a copy to the parties. See 34 Pa. Code §§ 127.472, 127.476. A party may appeal the URO's findings by filing a petition with the state, on yet another state prescribed form. See 77 Pa. Stat.Ann. § 531(6)(iv); 34 Pa. Code § 127.551. The state assigns the appeal to an administrative law judge, who engages in a *de novo* review, 77 Pa. Stat.Ann. § 531(6)(iv); 34 Pa. Code § 127.556, and makes the final determination as to whether the insurer must pay.

[2/] "I hereby request the Bureau of Workers' Compensation assign an authorized utilization review organization to review the reasonableness and necessity of proposed, current or past care of the above employee." "Utilization Review: Initial Request" J.A. at 5.

The state is thus intimately involved in every aspect of the dispute resolution process, from its creation of the utilization review system, to its authorization of the decision making body; from its assignment of the case, to its receipt of the report; from its provisions for notice, to its mechanisms for appeal. The state is overtly providing significant assistance to the insurer in tolling its obligation to pay worker's health benefits pending dispute resolution. As in *McCollum,* 505 U.S. at 52, *Edmonson*, 500 U.S. at 624, and *Tulsa Professional Collection Services, Inc.*, 485 U.S. at 486-487, the actions of the private entity are not self-executing; in those cases, courts were the state enablers, making it possible for the private actors to carry out the challenged activity, while, in this situation, the Bureau of Workers' Compensation plays a critical role in the continuum of activity which may result in the suspension of health coverage. Also, like the parking authority in *Burton*, the state has here created a partnership with the insurers to replace the tort system; this is a working or symbiotic relationship within a comprehensive statutory scheme, so that the state has "so far insinuated itself into a position of interdependence with [the private entity] that it must be recognized as a joint participant in the challenged activity." *Burton*, 365 U.S. at 725.

Second, the court below also recognized that the insurance companies' ability to "invoke the supersedeas, or to stop payments, is a power that traditionally was held in the hands of the State." *Sullivan,* 139 F.3d at 168.[10/] In creating and

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[10/] There has been some dispute about the *Edmonson* Court's elimination of the "exclusivity" element of the governmental function test. See, *e.g., United Auto Workers v. Gaston Festivals, Inc.*, 43 F.3d 902, 906 n.2 (4th Cir. 1995). This Court did take that action, however, and followed it in *McCollum*, 505 U.S. at 52. In light of the *Edmonson* decision to weigh several factors, rather than to require total compliance with one, it was logical to "delete the 'exclusivity' requirement and use the public function (continued...)

administering its worker's compensation system, the state is exercising its traditional police powers of resolving disputes and creating remedies for injuries to its citizens, and this Court has held that protecting the rights of litigants is a "critical governmental function." *Edmonson*, 500 U.S. at 624. In exchange for providing a courtroom forum in which injured workers may seek redress for their injuries, Pennsylvania has created administrative remedies, eliminating the need to prove fault and establishing a statutory obligation to pay medical benefits for the injured worker. Although the state compels the insurer to pay the benefits prior to a determination that the medical treatment is reasonable or necessary, the insurer may dispute that obligation, and, while seeking resolution by the state, may toll further payment. Tolling or suspension of a legal obligation pending dispute resolution is unquestionably a governmental function, one which courts and administrative agencies traditionally perform. See, *e.g., Mathews v. Eldridge*, 424 U.S. 319, 324 (1976) (Social Security Administration suspending disability benefits pending administrative and judicial review). Pennsylvania has thus delegated to insurers the discretion to delay their legal obligations when they invoke utilization review, the state-created forum for dispute resolution.

Third, the state's significant participation in the unilateral suspension of medical benefits prior to resolution of the dispute aggravates the deprivation. The critical feature of Pennsylvania's scheme is the substitution of guaranteed and quick wage and medical benefits for the possibility of obtaining, in the long run, economic damages, damages for pain and suffering, and punitive damages. This is a mandatory

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[10/] (...continued)
concept as part of a broader state action inquiry." *Mark*, 51 F.3d at 1157 n.2 (Greenberg, J., concurring); see also *id.* at 1157-1158.

and exclusive system, with the workers having no option. As the Third Circuit emphasized by comparing the injured workers to the prisoners in *West v. Atkins*, 487 U.S. 42 (1988), "they are locked into the system, and any relief that the employees obtain is strictly through the program which the State has designed." *Sullivan*, 139 F.3d at 169.

The balance of this scheme is greatly skewed, however, by the state's elimination of the right to immediate payment of medical benefits, which occurs when an insurance company invokes the state's procedures to delay or terminate the benefits pending the dispute resolution. And, it is unmistakably the state and its functionaries who ultimately determine whether the worker will receive medical benefits; even the Notice of Assignment for utilization review comes with the state's imprimatur, on Commonwealth letterhead complete with the Commonwealth's seal. It is the state which permits the insurer to cease payment even before the state has made its determination that the treatment was unreasonable -- despite the fact that one of the statute's fundamental premises was the guarantee of health care to injured workers.

Although the forum in which this deprivation takes place, the utilization review process, is administrative, it is as much a creature of the state as were the courts in *Edmonson*. Just as the courthouse in that situation served as the backdrop for, and provided the implicit approval of, racial discrimination, so too does the administrative process created by the state furnish the stage on which the insurers deprive injured workers of medical coverage.

In sum, the insurance companies' actions are intertwined with those of the state, and they can only suspend payments pursuant to that relationship and in reliance on state authority.

Furthermore, taking that action is the typical function of a state agency, as the insurers have been thrust into a role historically played by agencies. Finally, the state has aggravated the harm by locking injured workers into a system that was supposedly a fair replacement for the expense and vagaries of tort law but which instead authorizes unilateral and indefinite suspension of that most cherished of modern rights, health coverage. This situation is not a matter of mere state regulation, which alone is not sufficient to describe state action, see, *e.g.*, *Jackson v. Metropolitan Edison Co.*, 419 U.S. 345, 350 (1974), nor does it depict only a state reaction to an independent private decision made pursuant to professional standards, as in *Blum*, 457 U.S. at 1008-1009. The insurers' actions here are authorized by the state as part of a comprehensive state-created and -run scheme which encompasses all the participants in the drama: the employers, the insurers, the workers, and the state. When viewed in the totality of its circumstances which *Edmonson* demands, this scenario depicts the essence of state action.

CONCLUSION

The judgment of the court of appeals should be affirmed.

Respectfully submitted,

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